		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019596

Facility Name: Alden Morrow Rehab & HCC

Address: 5001 S. Michigan (Number) Chicago (City) 60615 (Zip Code)

County: Cook

Telephone Number: (773) 924-9292 **Fax #** (773) 924-1308

IDPA ID Number: 36-2814943

Date of Initial License for Current Owners: 11/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-6622

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Steven M. Kroll
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	192	Skilled (SNF)	192	70,272	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	192	TOTALS	192	70,272	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,016	509	707	10,232	8
9	SNF/PED					9
10	ICF	30,185	274	303	30,762	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,201	783	1,010	40,994	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.34%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started / /

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 423

Medicare Intermediary ADMINISTAR FEDERAL INC.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	182,125	28,214		210,339	895	211,234		211,234			1
2	Food Purchase		263,279		263,279	(33,220)	230,059	(19,271)	210,788			2
3	Housekeeping	124,948	20,804		145,752	266	146,018		146,018			3
4	Laundry	55,700	16,570		72,270	124	72,394		72,394			4
5	Heat and Other Utilities			146,551	146,551		146,551		146,551			5
6	Maintenance	25,502	8,377	136,476	170,355		170,355	4,873	175,228			6
7	Other (specify):*											7
8	**TOTAL General Services**	388,275	337,244	283,027	1,008,546	(31,935)	976,611	(14,398)	962,213			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,068,271	37,776	4,416	1,110,463	2,963	1,113,426	(238)	1,113,188			10
10a	Therapy											10a
11	Activities	55,836	508	2,176	58,520		58,520		58,520			11
12	Social Services	19,683		412	20,095		20,095		20,095			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*			90	90		90		90			15
16	**TOTAL Health Care and Programs**	1,143,790	38,284	19,094	1,201,168	2,963	1,204,131	(238)	1,203,893			16
	C. General Administration											
17	Administrative	76,011			76,011		76,011		76,011			17
18	Directors Fees											18
19	Professional Services			692,895	692,895		692,895	(613,103)	79,792			19
20	Dues, Fees, Subscriptions & Promotions			29,548	29,548		29,548	(18,946)	10,602			20
21	Clerical & General Office Expenses	339,706	23,565	19,778	383,049	209	383,258	37,135	420,393			21
22	Employee Benefits & Payroll Taxes			276,785	276,785	28,763	305,548	43,776	349,324			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,248	1,248		1,248	10,795	12,043			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			42,763	42,763		42,763	115	42,878			26
27	Other (specify):*			18,000	18,000		18,000	(18,000)				27
28	**TOTAL General Administration**	415,717	23,565	1,081,017	1,520,299	28,972	1,549,271	(558,228)	991,043			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,947,782	399,093	1,383,138	3,730,013		3,730,013	(572,864)	3,157,149			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Morrow Rehab & HCC #0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			72,830	72,830		72,830	85,077	157,907			30
31	Amortization of Pre-Op. & Org.							211	211			31
32	Interest			48,427	48,427		48,427	144,651	193,078			32
33	Real Estate Taxes			229,641	229,641		229,641	4,679	234,320			33
34	Rent-Facility & Grounds			581,420	581,420		581,420	(581,420)				34
35	Rent-Equipment & Vehicles			7,494	7,494		7,494	14,798	22,292			35
36	Other (specify):* MIP Insurance							(8,621)	(8,621)			36
37	**TOTAL Ownership**			939,812	939,812		939,812	(340,625)	599,187			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,170	32,562	72,732		72,732	(24,051)	48,681			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			105,408	105,408		105,408		105,408			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		40,170	137,970	178,140		178,140	(24,051)	154,089			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,947,782	439,263	2,460,920	4,847,965		4,847,965	(937,540)	3,910,425			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	69,762	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(336)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(47)	32		18
19	Entertainment				19
20	Contributions	(2,387)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)	27		24
25	Fund Raising, Advertising and Promotional	(16,554)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(861)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 31,577		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(516,960)	pg. 6'	34
35	Other- Attach Schedule	(452,157)	pg. 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (969,117)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (937,540)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Alden Morrow Rehab & HCC
ID# 0019596
Report Period Beginning: 01/01/00
Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	non-cost: hmo drugs supply (gl 5026)	$ (329)	39	1
2	non-cost: hmo drugs supply (gl 5042)	(388)	39	2
3	non-cost: hmo drugs supply (gl 5040)	59	39	3
4	non cost: part b therapy c/a's in 5212/5213/5214	(703)	39	4
5	non cost: hmo isolation c/a (gl 5093)	0	39	5
6	ELIMINATE RENT DUE TO SALE/LEASEBACK	(581,420)	34	6
7	MORTGAGE INTEREST	140,565	32	7
8	MIP INSURANCE	(8,621)	36	8
9	Help wanted adv. Prior year exp adj	437	20	9
10	reclass painting for 2000 from ln 6 to pg 22	(7,887)	6	10
11	record deprec exp on painting reclassed in 1999	4,815	6	11
12	record deprec exp on painting reclassed in 2000	1,315	6	12
13				13
14				14
15				15
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87				87
88				88
89				89
90	**Total**	(452,157)		90

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Alden Morrow Rehab & HCC **#** 0019596 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(336)	0	0	(18,935)	0	0	0	0	0	0	0	(19,271)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,757)	0	6,630	0	0	0	0	0	0	0	0	4,873	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,093)	0	6,630	(18,935)	0	0	0	0	0	0	0	(14,398)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(238)	0	0	0	0	0	0	(238)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	(238)	0	0	0	0	0	0	(238)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(612,994)	0	0	0	0	(109)	0	0	0	(613,103)	19
20	Fees, Subscriptions & Promotions	(19,365)	0	419	0	0	0	0	0	0	0	0	(18,946)	20
21	Clerical & General Office Expenses	0	0	27,945	7,602	1,588	0	0	0	0	0	0	37,135	21
22	Employee Benefits & Payroll Taxes	0	0	43,901	0	(125)	0	0	0	0	0	0	43,776	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	10,795	0	0	0	0	0	0	0	0	10,795	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	115	0	0	0	0	0	0	0	0	115	26
27	Other (specify):*	(18,000)	0	0	0	0	0	0	0	0	0	0	(18,000)	27
28	**TOTAL General Administration**	(37,365)	0	(529,819)	7,602	1,463	0	0	(109)	0	0	0	(558,228)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,458)	0	(523,189)	(11,333)	1,225	0	0	(109)	0	0	0	(572,864)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	69,762	0	15,315	0	0	0	0	0	0	0	0	85,077	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	211	0	0	0	0	211	31
32	Interest	140,518	0	3,784	0	0	0	349	0	0	0	0	144,651	32
33	Real Estate Taxes	0	0	4,679	0	0	0	0	0	0	0	0	4,679	33
34	Rent-Facility & Grounds	(581,420)	0	0	0	0	0	0	0	0	0	0	(581,420)	34
35	Rent-Equipment & Vehicles	0	0	14,798	0	0	0	0	0	0	0	0	14,798	35
36	Other (specify):*	(8,621)	0	0	0	0	0	0	0	0	0	0	(8,621)	36
37	**TOTAL Ownership**	(379,761)	0	38,576	0	0	0	560	0	0	0	0	(340,625)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(1,361)	0	0	(7,580)	(5,373)	0	(9,737)	0	0	0	0	(24,051)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,361)	0	0	(7,580)	(5,373)	0	(9,737)	0	0	0	0	(24,051)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(420,580)	0	(484,613)	(18,913)	(4,148)	0	(9,177)	(109)	0	0	0	(937,540)	45

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ALDEN MANAGEMENT SERVICES	100%	SEE PG. 6K-TOO MANY TO FIT HERE.				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance/utilities	$	Alden Management Services, Inc.	100.00%	$ 6,630	$ 6,630	15
16	V	19	professional fees	622,080	Alden Management Services, Inc.		9,086	(612,994)	16
17	V	20	licenses/fees		Alden Management Services, Inc.		419	419	17
18	V	21	gen'l & admin		Alden Management Services, Inc.		27,945	27,945	18
19	V	22	employee costs		Alden Management Services, Inc.		43,901	43,901	19
20	V	24	auto/seminar		Alden Management Services, Inc.		10,795	10,795	20
21	V	26	insurance		Alden Management Services, Inc.		115	115	21
22	V	30	depreciation		Alden Management Services, Inc.		15,315	15,315	22
23	V	32	interest		Alden Management Services, Inc.		3,784	3,784	23
24	V	33	real estate tax		Alden Management Services, Inc.		4,679	4,679	24
25	V	35	auto lease		Alden Management Services, Inc.		14,798	14,798	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 622,080			$ 137,467	$ * (484,613)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		2	tube feeding	$ 25,698	Pyramid Healthcare Services	0.00%	$ 6,763	$ (18,935)	15
16	V		39	nursing supplies	7,984	Pyramid Healthcare Services		1,737	(6,247)	16
17	V		39	supplies/per diem fees	3,704	Pyramid Healthcare Services		2,371	(1,333)	17
18	V		21	general & administrative				7,602	7,602	18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 37,386			$ 18,473	$ * (18,913)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	$ 21,231	Forum Extended Care II	0.00%	$ 15,981	$ (5,250)	15
16	V	10	house stock	961	Forum Extended Care II		723	(238)	16
17	V	39	iv	500	Forum Extended Care II		377	(123)	17
18	V	22	employee vaccinations	505	Forum Extended Care II		380	(125)	18
19	V	21	general & administrative		Forum Extended Care II		1,588	1,588	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 23,197			$ 19,049	$ * (4,148)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	CPT REVENUES	$ 30,184	COMMUNITY PHYSICAL THERAPY	100.00%	$ 20,447	$ (9,737)	15
16	V	31	AMORTIZATION		COMMUNITY PHYSICAL THERAPY		211	211	16
17	V	32	INTEREST		COMMUNITY PHYSICAL THERAPY		349	349	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 30,184			$ 21,007	$ * (9,177)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		19	construction management fees	$ 7,755	Alden Bennet Construction	0.00%	$ 7,646	$ (109)	15
16	V		19	design fees	413	Alden Design		413		16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 8,168			$ 8,059	$ * (109)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg	President-AMS	Chief Executive	100.00%	186,228	1.692	4.23	Salary	$ 8,218	21-1	1
2	Lauren Magnusson	Clinical Coordinator	Nursing review	a	71,341	1.692	4.23	Salary	3,148	21-1	2
3	Terry Magnusson	Administrator/other	Admin/Mainten	b	72,323	1.692	4.23	Salary	1,297	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10	a. Lauren Magnusson is the daughter of Floyd Schlossberg and worked as a Clinical Coordinator for Alden Management Services for all of 2000.										10
11	b. Terry Magnusson is the son-in-law of Floyd Schlossberg and worked as the Administrator of Alden Valley Ridge for seven months thereafter he worked as in										11
12	Construction/Maintenance for Alden Management Services.										12
13								TOTAL	$ 12,663		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc.
Street Address: 4200 W. Peterson
City / State / Zip Code: Chicago, Illinois 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		SEE PAGE 8 A								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	PRO FORMA ALLOCATION						$	$			$	1
2	OF INTEREST EXPENSE											2
3	PRIOR TO SALE/LEASEBACK		X	MORTGAGE	$15,474.67	3/7/75	2,166,900	1,679,071	8/20/17	0.0825	140,565	3
4												4
5												5
	Working Capital											
6	LINE OF CREDIT		X	OPERATIONS	NONE					VARIES	48,380	6
7	RELATED PARTY- CPT	X		OPERATIONS	NONE					VARIES	349	7
8	RELATED PARTY - AMS	X		OPERATIONS	NONE					VARIES	3,784	8
9	TOTAL Facility Related				$15,474.67		$ 2,166,900	$ 1,679,071			$ 193,078	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,166,900	$ 1,679,071			$ 193,078	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	244,464	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	231,271	2
3. Under or (over) accrual (line 2 minus line 1).	$	(13,193)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	242,834	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	229,641	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	233,724	8
	1996	239,476	9
	1997	228,762	10
	1998	232,823	11
	1999	231,271	12

LINE 4:2000 ACCRUAL BASED ON 5% INCREASE OF PRIOR YEAR BILL: $231,271*1.05=242,834

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1974	$ 80,500	1
2					2
3	TOTALS			$ 80,500	3

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	192		1976	1976	$ 1,860,675	$	30	$ 62,023	$ 62,023	$ 1,485,473	4
5			1976	1976	147,556		30	4,919	4,919	118,740	5
6											6
7											7
8											8
	Improvement Type**										
9	ELEVATOR			1976	70,500		25	2,820	2,820	70,500	9
10	AIR CONDITIONER/PAINTING/SMOKE DRAPERIES			1978	14,584		4,7 & 8			14,584	10
11	DOOR/ESECT REPAIR/PANELS			1979	3,382		4 & 8			3,382	11
12	PAINTING			1981	7,954		3 & 5			7,954	12
13	PAINTING/ELECTRICAL WIRING/ELEVATOR REPAIR/A/C			1982	20,715		3,6,8 & 10			20,715	13
14	CHIMNEY/BASEBOARDS			1983	8,216		10 & 18			8,216	14
15	HOT WATER SYSTEM			1984	4,288		10			4,288	15
16	WALL/HANDRAIL/PLUMBING/ELECT REPAIR/PAINT/HVAC			1985	33,370		3,10 & 20			33,370	16
17	HEATING/PAINTING/MISC. REPAIR			1986	33,351		3,4,5,10&20			33,351	17
18	REPLACE CLOSET DOORS			1991	2,201		5			2,201	18
19	LOCKS/ROOFING			1994	9,675	968	10	968		5,966	19
20	REPLACE LEAKING PUMP			1995	2,057	137	15	137		777	20
21	WASCOMAT WASHTOWN			1987	2,175		3			2,175	21
22	WHEELCHAIR REPAIR/PLUMBING/PAINTING/CARPENTRY			1988	35,223		5 & 10			35,223	22
23	PLUMBING/MISC. REPAIRS			1989	21,020		5			21,020	23
24	ELEVATOR REPAIR			1990	2,900		5			2,900	24
25	REPLACE BLOWER MOTOR/FREEZER/CONDENSOR/BOILER			1991	22,644		5			22,644	25
26	FIRE ALARM/REPAIR PUMP/ELEVATOR REPAIR/MISC.			1992	30,274	310	5,10 & 15	310		28,705	26
27	REPAIR 3-WAY VALVES/AIR CONDENSOR/CAULKING/MSC			1993	14,638		5			14,638	27
28	ROOFING			1994	12,070	1,207	10	1,207		7,843	28
29	CONTROLS/PIPING/ROOF/VALVES/AC MOTOR & PUMP/MSC			1995	58,213	5,697	5,10,15&20	5,697		43,077	29
30	BOILER LEAKING & REPLACE TUBES			1996	7,674	512	15	512		2,387	30
31	BOILER TUBE			1996	5,700	380	15	380		1,647	31
32	BOILER TUBE			1996	5,699	380	15	380		1,583	32
33	HVAC			1996	238,155	9,526	25	9,526		40,486	33
34	INSTALL ELECTRICAL WIRING FOR DRYERS			1996	1,838	368	5	368		1,501	34
35	ABC-drywall for dryers			1996	1,105	203	5	203		1,105	35
36	TOTAL (lines 4 thru 35)				$ 2,677,851	$ 19,687		$ 89,449	$ 69,762	$ 2,036,450	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	INSTALL SPRINKLER HEADS			1998	1,879	376	5	376		971	9
10	REPAIR FREON LEAKS			1998	5,391	1,078	5	1,078		2,785	10
11	REPAIR CHILLER			1998	4,930	493	10	493		1,232	11
12	REPAIR CONVECTION STEAMER			1998	2,230	223	10	223		539	12
13	ELECTRICAL WORK			1998	1,901	190	10	190		444	13
14	AIR CONDITIONERS			1998	68,504	4,567	15	4,567		10,656	14
15	AIR CONDITIONERS			1998	10,000	667	15	667		1,556	15
16	INSTALL DOOR RESTRICTOR			1998	3,400	170	20	170		482	16
17	ABC-CONCRETE PATIO			1999	7,346	735	10	735		857	17
18	Atash Fire & Safety Equipment (install alarm)			1999	12,400	827	15	827		1,653	18
19	Climate Service (repair leaks and air/water heating)			1999	10,519	701	15	701		1,403	19
20	Alden Bennett Construction(general construction)			1999	2,648	265	10	265		353	20
21	Climate Service(repair)			1999	1,676	112	15	112		140	21
22	Climate Service (repair pipes)			1999	1,565	104	15	104		122	22
23	Alden Bennett Construction(general construction)			1999	922	184	5	184		200	23
24	Alden Bennett Construction(general construction)			1999	6,329	633	10	633		686	24
25	Alden Bennett Construction(general construction)			1999	3,598	360	10	360		390	25
26	Alden Bennett Construction(general construction)			1999	4,089	409	10	409		443	26
27	Security Services Group(window detector system)			1999	4,687	312	15	312		312	27
28	CSI-fixed leaking coil			1998	3,526	705	5	705		1,822	28
29	ABC-various leasehold improvements			1999	45,440	4,544	10	4,544		4,544	29
30	Climate Service Inc (repair HVAC)			2000	1,696	113	15	113		113	30
31	Climate Service Inc (repair HVAC)			2000	2,283	152	15	152		152	31
32	Climate Service Inc (repair HVAC)			2000	1,509	94	16	94		94	32
33	GT Mechanical Inc			2000	5,000	222	15	222		222	33
34	Alden Bennett Construction (general construction)			2000	11,602	677	10	677		677	34
35	Alden Bennett Construction (general construction)			2000	16,663	833	10	833		833	35
36	TOTAL (lines 4 thru 35)				$ 241,733	$ 19,747		$ 19,747	$	$ 33,680	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fox Valley (ansulator)			2000	2,007	84	10	84		84	9
10	CSI Coker Service (kitchen dishwasher)			2000	3,487	29	10	29		29	10
11	Alden Bennett Construction			2000	4,436	259	10	259		259	11
12	Alden Bennett Construction			2000	7,346	367	10	367		367	12
13	Alden Bennett Construction			2000	21,382	1,069	10	1,069		1,069	13
14	Alden Bennett Construction (leashold imprv.)			2000	8,803	660	10	660		660	14
15											15
16											16
17	continue…										17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 47,462	$ 2,468		$ 2,468	$	$ 2,468	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related			1978	$ 12,184	$ 554	22	$ 554	$	$ 11,565	4
5	Party			1978	5,953	271	32	271		4,767	5
6	(Forum)										6
7											7
8											8
	Improvement Type**										
9	Related Party - AMS:										9
10	Leasehold Improvement - Remodeling			1993	5,378	223	various	223		115,184	10
11	Leasehold Improvement - Remodeling			1994	2,663	407	various	407		55,299	11
12											12
13	Related Party - Forum:										13
14	Leasehold Improvement - Remodeling			1980	19,102	955	20	955		19,102	14
15	Leasehold Improvement - Remodeling			1980	113		10			113	15
16	Leasehold Improvement - Remodeling			1986	32		6			32	16
17	Leasehold Improvement - Remodeling			1990	51		5			51	17
18	Leasehold Improvement - Remodeling			1991	12		5			12	18
19	Leasehold Improvement - Remodeling			1993	4,085	408	10	408		4,085	19
20	Leasehold Improvement - Remodeling			1993	3,199	330	9.7	330		3,058	20
21	Leasehold Improvement - SIGN			1994	258	21	10	21		145	21
22	Leasehold Improvement - DRYVIT			1994	437	44	12	44		244	22
23	Leasehold Improvement - NEW AC			1995	714	48	10	48		71	23
24	Leasehold Improvement - Roof			1997	961	51	10	51		760	24
25	Leasehold Improvement - Roof			1998	853	57	10	57		369	25
26	Leasehold Improvements-Roof			1985	809	54	19	54		175	26
27	Leasehold Improvements-Roof			1999	1,373	92	15	92		198	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 58,177	$ 3,514		$ 3,514	$	$ 215,231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 338,364	$ 33,480	$ 33,480	$	varies	$ 209,394	37
38	Current Year Purchases	58,868	5,541	5,541		varies	5,541	38
39	Fully Depreciated Assets	73,265	1,214	1,214		varies	73,265	39
40								40
41	TOTALS	$ 470,497	$ 40,235	$ 40,235	$		$ 288,200	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	various	van, busses, engine	1998-2000	$ 26,682	$ 2,494	$ 2,494	$	3	$ 3,030	42
43										43
44										44
45										45
46	TOTALS			$ 26,682	$ 2,494	$ 2,494	$		$ 3,030	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,602,903	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 88,145	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 157,907	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 69,762	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,579,059	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: OMEGA HEALTHCARE INVESTORS
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		192	10/29/86	$	10	5	3
4	Additions							4
5								5
6								6
7	TOTAL		192		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [ ] YES [X] NO Terms: RIGHT OF FIRST REFUSAL *

10. Effective dates of current rental agreement:
Beginning 10/31/86
Ending 10/31/01

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 581,420
13.	/2002	$ 581,420
14.	/2003	$ 0

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 7,494 Description: COPY MACHINE LEASE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	RELATED PARTY	VARIOUS	$ 1,233.00	$ 14,798	17
18					18
19					19
20					20
21	TOTAL		$ 1,233.00	$ 14,798	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   SKILLED NURSING IS ALREADY ON SITE

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 14,723	$		$ 14,723	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,628			1,628	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			13,833			13,833	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	SEE PG 16A…	# of prescrpts				15,860		15,860	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	SEE PG 16A…					2,637		2,637	13
14	TOTAL			$		$ 30,184	$ 18,497		$ 48,681	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 15,113	$	1
2	Cash-Patient Deposits	1,560		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (48,626))	841,836		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	125,375		6
7	Other Prepaid Expenses	500		7
8	Accounts Receivable (owners or related parties)	1,820,238		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,804,622	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	972,111		15
16	Equipment, at Historical Cost	400,408		16
17	Accumulated Depreciation (book methods)	(687,260)		17
18	Deferred Charges	32,110		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 717,369	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,521,990	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,399,634	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	66,396		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	162,786		30
31	Accrued Taxes Payable (excluding real estate taxes)	(46,372)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	242,834		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	498,750		35
	Other Current Liabilities(specify):			
36				36
37	accrued expenses/due idpa/various	747,032		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,071,060	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,071,060	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 450,930	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,521,990	$	48

*(See instructions.)

Facility Name & ID Number Alden Morrow Rehab & HCC **#** 0019596 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,503,230	1
2	Restatements (describe):		2
3	external auditors' adjustments made after 1999 cost report		3
4	was filed: these adjustments have no effect on reimbursable		4
5	costs: bad debts and medicare revenue were adj.	(588,286)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 914,944	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(464,014)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (464,014)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 450,930	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,077,334	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,077,334	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,672	6
7	Oxygen	3,273	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,946	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	38	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(11,878)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ (11,840)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	adjustments to prior year expenses. Since prior year rep.	7,588	28
28a	were not used , we made no offsetting adj's on p.5 or 5A.		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,588	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,083,043	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,008,546	31
32	Health Care	1,201,168	32
33	General Administration	1,219,391	33
	B. Capital Expense		
34	Ownership	939,812	34
	C. Ancillary Expense		
35	Special Cost Centers	72,732	35
36	Provider Participation Fee	105,408	36
	D. Other Expenses (specify):		
37	Note: this will not balance to page 3 & 4 due to related party		37
38	information input to these pages.		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,547,057	40
41	**Income before Income Taxes (line 30 minus line 40)****	(464,014)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (464,014)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,480	2,760	$ 65,025	$ 23.56	1
2	Assistant Director of Nursing	1,802	1,938	45,153	23.30	2
3	Registered Nurses	4,982	5,327	123,152	23.12	3
4	Licensed Practical Nurses	21,032	23,144	366,086	15.82	4
5	Nurse Aides & Orderlies	54,196	60,402	426,544	7.06	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,856	2,095	23,225	11.09	9
10	Activity Assistants	3,341	3,767	32,268	8.57	10
11	Social Service Workers	1,312	1,480	19,683	13.30	11
12	Dietician					12
13	Food Service Supervisor	2,380	2,700	33,896	12.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,558	22,055	148,230	6.72	15
16	Dishwashers					16
17	Maintenance Workers	1,872	2,080	25,502	12.26	17
18	Housekeepers	16,989	18,704	124,949	6.68	18
19	Laundry	7,308	8,049	55,700	6.92	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	7,762	8,486	85,957	10.13	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,960	2,103	42,653	20.28	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Clinical supervisor	768	792	28,852	36.43	33
34	TOTAL (lines 1 - 33)	150,598	165,882	$ 1,646,875 *	$ 9.93	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	41	2,176	11-3	44
45	Social Service Consultant	8	412	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	49	$ 2,588		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
FAITH OSEMWENGIE	ADMINISTRATOR		$ 76,011
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,011

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alden Management Services	MNGT. FEES	$ 622,080
Blackman Kallick	ACCTG. FEES	12,100
Ken J. Fisch	LEGAL FEES	15,051
Greenburg & Herman	LEGAL FEES	3,344
Other misc. legal fees	LEGAL FEES	4,593
ACHIEVE ACCREDITATION	JHCACO Consult	824
US GAS	Utility Consultant	864
SMS	MEDICAL CONSULT.	23,934
MISC. PROF FEE	PROF. FEES	1,938
PROF. FEE ALDEN DESIGN	DESIGN FEES	413
PROF. FEE ABC	CONSTRUC FEES	7,755
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 692,895

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,842
Unemployment Compensation Insurance	19,607
FICA Taxes	128,020
Employee Health Insurance	38,306
Employee Meals	33,220
Illinois Municipal Retirement Fund (IMRF)*	
RELATED PARTY	43,776
UNION HEALTH & WELFARE INSURANCE	36,256
EMP. RELATIONS/TUITION REIMBURSE	1,562
DENTAL / LIFE / INSURANCE	1,699
EMP. VACCINATIONS	505
PENSION / 401 K	16,531
TOTAL (agree to Schedule V, line 22, col.8)	$ 349,324

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
RELATED PARTY	419
CITY OF CHICAGO LICENSE	1,000
MISC. INPECTIONS	446
IHCA	8,737
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,602

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
EMPLOYEE SEMINARS	1,248
RELATED PARTY	10,795
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,043

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	hvac/painting	1-10/89	$ 36,448	5	$	$	$	$	$	$	$	$	$
2	hvac repair	8/90	2,612	5									
3	hvac/painting/boiler rep's.	6-11/92	18,988	3-15	1,909	224	224	224	224	224	224	224	224
4	pump/paint./compress.	1-10/93	32,016	3									
5	painting/pump repairs	2-11/94	10,007	3	1,036	0							
6	painting	4-12/95	7,922	3	2,641	1,640	0						
7	hvac/pipes/boiler/paint'g	1-12/96	61,716	3-20	13,276	13,276	5,092	2,579	1,832	1,552	1,552	1,552	1,552
8	hvac repairs	1-12/97	22,597	3	4,660	7,532	7,532	2,872	0				
9	replace actuator/hvac	9/98	1,872	3		208	624	624	416	0			
10	repair a/c-Chic. Cool'g	10/99	3,529	3			294	1,176	1,176	882	0		
11	Painting>$1,500 ytd	7/99	14,444	3			2,407	4,815	4,815	2,408	0		
12	GT Mechanical (repair Va	5/00	2,168	3				482	723	723	240	0	
13	Alden Bennett (painting)	4/00	14,701	3				3,675	4,900	4,900	1,226	0	
14	Alden Bennett (landscapin	4/00	1,337	3				334	446	446	111	0	
15	GT Mechanical	10/00	2,949	3				246	983	983	737	0	
16	painting>$1500 for 2000	7/00	7,887	3				1,315	2,629	2,629	1,315	0	
17													
18													
19													
20	TOTALS		$ 241,194		$ 23,522	$ 22,880	$ 16,173	$ 18,342	$ 18,144	$ 14,747	$ 5,405	$ 1,776	$ 1,776

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Health Care Assoc. / $6,079**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **15 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,260** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **YES**
If YES, give effective date of lease. **10/29/86**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **105,408**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **33,220** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Blackman Kallick Bartlestein, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **not yet completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees